U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 07 April 2005

In the Matter of:

JACK R. FRANCISCO,
Claimant,

v.

STRAIGHT CREEK COAL RESOURCES,
Employer

and

HORIZON NATURAL RESOURCES,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Case No.: 2003-BLA-6526

Appearances:

John Hunt Morgan, Esq.
Edmond Collett, PSC
Hyden, Kentucky
For the Claimant

Carl M. Brashear, Esq.
Hoskins Law Offices
Lexington, Kentucky
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2004). In this case, the Claimant, Jack R. Francisco, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on January 13, 2004, in Knoxville, Tennessee. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 C.F.R. Part 18 (2004). At the hearing, the Claimant was the only witness. Administrative Law Judge's Exhibit ("ALJX") 1, Director's Exhibits ("DX") 1-34, Claimant's Exhibit ("CX") 1, and Employer's Exhibits ("EX") 1 and 2 were admitted into evidence without objection.[1] Transcript ("Tr.") at 7, 8, 10 and 13. The record remained open for the receipt of two x-ray interpretations. Tr. 29-30. These x-ray readings have been admitted, along with the qualifications of the readers, as CX 2 and 3, and EX 3. The Claimant and the Employer submitted closing briefs, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing and deposition, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed this claim for benefits on May 24, 2002. DX-2. On July 2, 2003, the District Director issued a proposed Decision and Order denying the claim. DX-30. On July 18, 2003, the Claimant requested a hearing. DX-31. The claim was referred to the Office of

[1] Initially counsel for the Claimant objected that the Employer had exceeded the limitations on medical evidence contained in the regulations. Upon further discussion and review of the Evidence Summary Form submitted on behalf of the Employer, however, it became apparent that the form was misleading, in that it listed the evidence submitted by all parties, and not just the evidence relied upon by the Employer, whereupon counsel for the Claimant withdrew his objection. Tr. at 9-10. Upon review of the file after the hearing, however, I have determined that the Employer did exceed the evidentiary limitations with regard to readings of the x-rays taken August 12 and November 23, 2002. As the Benefits Review Board has held that the limits are mandatory and cannot be waived by the parties, *Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-___, BRB No. 04-126 BLA, slip op. at 4-5 (Oct. 27, 2004) (unpub.) (to be published pursuant to the BRB's January 26, 2005 Order), and the Employer did not show good cause for admitting the extra x-ray readings, I have not considered x-ray readings in excess of the limitations.

Administrative Law Judges for a hearing on August 19, 2003. DX-34.

APPLICABLE STANDARDS

This claim was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations. For this reason, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2004). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2004).

ISSUES

The issues contested by the Director and Employer are:

1. The length of the Claimant's coal mine employment.

2. Whether the Claimant has pneumoconiosis as defined in the Act and the regulations.

3. Whether his pneumoconiosis arose out of coal mine employment.

4. Whether the Claimant is totally disabled.

5. Whether his total disability is due to pneumoconiosis.

The Employer withdrew the issues of whether it had been properly named as the responsible operator, timeliness, and whether Mr. Francisco was a miner, employed in the mines after 1969; and reserved its right to challenge the regulations and its potential liability for medical expenses for purposes of appeal. Tr. at 5-6; DX-34.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified at the hearing, and was also deposed. Mr. Francisco was born in 1938, and was 65 years old at the time of the hearing. He graduated from high school in 1956, and attended two years of college. He has one dependent, namely his wife, Alice, whom he married in 1960. Tr. at 14-15; DX 5 (Claimant's Deposition) at 4-5; DX 10.

Mr. Francisco testified that he worked about 26 years in the mines, starting in 1957, and quitting in 1998. Tr. at 15; *see also* DX 5 at 5-11, 6; DX 3; DX 4. He said that he initially worked with Silas Campbell Contractors, Inc., for periods between 1957 and 1963. Tr. at 15-16. This employment consisted of construction and maintenance work at and around coal preparation plants. Tr. at 16. DX-5 (Claimant's Deposition) at 7. The Social Security earnings records, admitted as Director's Exhibit 9, reflect approximately three years of employment between 1957 and the latter part of 1962 with Silas Campbell Contractors and Kentucky Ridge Coals

Company. He left the mines for a time, only to resume coal mining in 1973, when he was employed by Cypress Cumberland, a predecessor company to Straight Creek, as a repairman, welder and maintenance person around coal tipples and preparation plants. Tr. at 17-18. His last coal mine employment occurred in Kentucky. Tr. at 24. Therefore, this claim is governed by the law of the United States Court of Appeals for the Sixth Circuit. *Kopp v. Director*, *OWCP*, 877 F.2d 307, 12 B.L.R. 2-299 (4th Cir. 1989); *Shupe v. Director*, *OWCP*, 12 B.L.R. 1-200 (1989) (*en banc*).

Asked about his breathing problems, Mr. Francisco testified that when walking, especially on an incline, he has to sit down occasionally to rest. He sleeps sitting up because he fares better that way. He has shortness of breath, and sometimes gasps for breath uncontrollably. Sometimes he coughs for as much as 30 minutes or more, usually a dry cough. He uses inhalers. Tr. at 20-21. At the time of the hearing, he was receiving Social Security benefits and a small pension. Initially, his Social Security benefits were based on a disability, which then converted to retirement. Tr. at 21-22. Doctors who examined him during the course of his claim included Dr. Simpao, for the Department of Labor, and Dr. Baker, to whom he has returned for treatment. He also sees Dr. Russell once a year. Dr. Baker and Dr. Russell both prescribe his inhalers. Tr. at 22-23. He sees Dr. Baker about every two or three months. Tr. at 26.

Length of Employment

Claimant has the burden of establishing the length of his qualifying coal mine employment, *Shelesky v. Director, OWCP*, 7 B.L.R. 1-34 (1984). Credible lay evidence and affidavits may constitute sufficient proof of coal mine employment. *Justice v. Island Creek Coal Co*. 11 B.L.R. 1-91 (1988). *See generally Migliorini v. Director, OWCP*, 898 F.2d 1292, 1294-95, 13 B.L.R. 2-418 (7th Cir.), *cert. denied* 498 U.S. 958 (1990). The Act provides no established methodology for computing the length of a miner's coal mine employment, provided all relevant evidence on this issue is evaluated and adequate findings made. The Claimant alleged that he completed approximately 26 years of coal mine employment. Upon independent review of the records and the Claimant's testimony, I credit Mr. Francisco with 25 years of coal mine employment. Although the District Director found 22 years and 11 months of coal mine employment, I will credit the Claimant's testimony with respect to the additional coal mine employment for the intermittent periods of work with Silas Campbell between 1957 and 1962 on the basis of his credible testimony and the Social Security earnings records for that period. In so doing, I specifically find that the Claimant was a "miner" in performing this work, and that the record contains no evidence to the contrary. *See* 20 C.F.R. §§ 725.202(a), (b) (2004).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2004). One x-ray interpretation which made no reference to pneumoconiosis, positive or negative, given in connection with review of an x-ray film solely to determine its quality, is listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and the registry of physicians' specialties maintained by the American Board of Medical Specialties. [2] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
07-18-02		DX-13 Dahhan (B) 0/0	
08-12-02	DX-12 Simpao (A) 1/1	EX-2 Kendall (B/BCR)[3]	DX-12 Goldstein (B) Quality 1 = Good

[2]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www2a.cdc.gov/drds/breaders/breaders_results.asp. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

[3] The negative reading by Dr. Halbert (B/BCR), submitted by the Employer, found in DX-16, has been excluded from consideration as exceeding the evidentiary limitations contained in the regulations with no showing of good cause for its admission.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
11-23-02	DX-14 Baker (B) 1/0	EX-1 Kendall (B/BCR)[4]	
02-17-04	CX-2 Alexander (B/BCR) 1/0	EX-3 Dahhan (B)	

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2004).

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX-13 07-18-02 Dahhan	64 69.3" (176 cm)	3.37	4.00	84%	60	No	Normal. MVV invalid.
DX-12 08-12-02 Simpao	64 70"[5]	3.56	4.41	81%	78	No	Normal.

[4] The negative reading by Dr. Halbert (B/BCR), submitted by the Employer, found in DX-17, has been excluded from consideration as exceeding the evidentiary limitations contained in the regulations with no showing of good cause for its admission.

[5] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 69.3" to 70", I have taken the average (69.8") in determining whether the studies qualify to show disability under the regulations. None of the tests are qualifying to show disability whether considering the average height, or the heights listed by the persons who administered the testing.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX-14 11-23-02 Baker	64 70"	3.25	4.13	79%		No	Within normal limits
DX-15 01-30-03 Baker	64 70"	2.69	4.48	65%		No	[Test results & tracings largely illegible]

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2004).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX-13	07-18-02	Dahhan	36.6 34.7	86.5 98.8	No No	Normal
DX-12	08-12-02	Simpao	35.8	90.7	No	Normal
DX-14	11-23-02	Baker	34	76	No	Mild resting hypoxemia

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2004). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms,

pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2004). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2004). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2004). The record contains the following medical opinions relating to this case.

Dr. A. Dahhan

The Claimant was examined for the Employer by Dr. Dahhan on July 18, 2002. Dr. Dahhan reported on this examination by report dated July 25, 2002. DX-13. Dr. Dahhan is board certified in internal medicine and pulmonary medicine, and a B-reader. The doctor recorded an employment history of 26 years in the mines, "outside loading trains and as a maintenance and tipple man," and noted that Claimant had never smoked. Mr. Francisco recounted a history of arthritis and peptic ulcer, with medications needed to address those conditions. He told Dr. Dahhan that he has a history of daily productive cough, and claimed to suffer dyspnea on exertion such as climbing a flight of stairs. The Claimant also experiences chest pain.

On examination of the chest, Dr. Dahhan noted "good air entry to both lungs with no crepitation, rhonchi or wheeze." "Cardiac examination showed regular rhythm with normal heart sounds." The EKG showed a normal sinus rhythm. Dr. Dahhan's examination of the extremities revealed no clubbing or edema. The doctor characterized the arterial blood gas and pulmonary function tests as "normal," with an "invalid" MVV. The chest x-ray demonstrated "clear lungs."

Dr. Dahhan concluded:

> In conclusion, based on the above occupational, clinical, radiological and physiological evaluation of this patient ... he has no evidence of occupational pneumoconiosis or pulmonary disability secondary to coal dust exposure as demonstrated by the normal clinical examination of the chest, normal spirometry, normal blood gases at rest and after exercise and clear chest x-ray.
>
> Based on my overall evaluation ... [the Claimant] retains the respiratory capacity to continue his previous coal mining work or job of comparable physical demand with no evidence of pulmonary impairment and/or disability caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

Dr. Dahhan diagnosed "essential hypertension, post laminectomy, arthritis and peptic

ulcer disease." None of these conditions were due to Mr. Francisco's coal mine employment, according to Dr. Dahhan.

Dr. Valentino S. Simpao

The Claimant was examined by Dr. Simpao for the Department of Labor on August 12, 2002. DX-12. Dr. Simpao is the Medical Director of the Coal Miners' Respiratory Clinic in Greenville, Kentucky. CX-1. His resume does not indicate that he is board certified in any specialty, and he is not listed on the American Board of Medical Specialties' web site. During his examination, Mr. Francisco recounted with a medical history of attacks of wheezing, arthritis and high blood pressure. His present complaints included wheezing, a daily productive cough, dyspnea, chest pain, orthopnea and paroxysmal nocturnal dyspnea. Most of these conditions had existed for the last three or four years. He is a non-smoker. Mr. Francisco related that he would "notice a change" on walking 150 feet, climbing up 20 stairs and lifting 25 pounds.

Dr. Simpao incorporated the results of a physical examination, the patient complaints, chest x-ray and clinical testing in rendering his opinions. On physical examination, he observed on palpation "tactile fremitus increased right over left." On percussion of the chest he noted "increased resonance upper chest & axillary areas." On auscultation of the chest, Dr. Simpao observed "few crepitations [with] occasional forced expiratory wheezes." The examination of the extremities showed that the Claimant's face was "slightly plethoric," the lips and nails were "slightly cyanotic." Dr. Simpao observed the Claimant walk 50 feet and climb 14 steps before he became short of breath. Mr. Francisco told the doctor that he took Robitussin, Daypro, Prilosec and Prinivil.

Dr. Simpao diagnosed coal workers' pneumoconiosis "1/1." As to the etiology, he explained "Multiple year of coal dust exposure is medically significant in his pulmonary impairment." On a separate sheet, he further elaborated "Findings on the chest x-ray along with physical findings and symptomatology."

The doctor assessed a "mild impairment," and checked a "No" box when asked to indicate whether the Claimant had the respiratory capacity to "perform the work of a coal miner or to perform comparable work in a dust free environment." He explained this assessment as based on "Objective findings on the chest x-ray along with symptomatology and physical findings as noted in the report."

Dr. Glen R. Baker

Dr. Baker first examined the Claimant at the request of his counsel on November 23, 2002, and prepared his medical report on that date. DX-14. Dr. Baker is board certified in internal medicine and pulmonary medicine. He is also a B-reader. The Claimant related a coal mine employment history of 26 years in surface mining, and told Dr. Baker that he worked in maintenance around tipples, doing repair work, shoveling and that he loaded trains. Mr. Francisco never smoked.

He told Dr. Baker that he has had progressive difficulty with his breathing for 6-8 years,

and that these symptoms are accompanied by daily symptoms of productive coughing. Mr. Francisco complained of wheezing "but not on a daily basis." He also told Dr. Baker that he suffers from shortness of breath, occasional cough and sputum production in the morning. His breathing is aggravated by exertion, and he said that he needs to sit in a chair or use two pillows to sleep at night. The Claimant also reported that his breathing is aggravated by exertion, and that he could walk about one hundred yards on level ground before needing to stop and catch his breath. Dr. Baker noted that the Claimant takes Combivent for his pulmonary complaints, as well as several other medications.

On physical examination, Dr. Baker observed that the Claimant's lungs were "[c]lear, no rales or wheezes noted." The extremities showed no clubbing, cyanosis or edema. The pulmonary function studies produced normal results, and Mr. Francisco's arterial blood gas test indicated a "mild resting hypoxemia." The heart showed a regular rhythm.

Dr. Baker diagnosed "coal workers' pneumoconiosis, category 1/0 – on basis of 1980 ILO classification." He also diagnosed "Chronic Bronchitis -- based on history."

He concluded that the Claimant "has a Class 1 impairment with the vital capacity and FEV1 both being greater than 80% of predicted. This is based on Table 5-12, Page 107, Chapter Five, Guides to the Evaluation of Permanent Impairment, Fifth Edition." The doctor also rendered a contraindication assessment, stating that with his pneumoconiosis, the Claimant "should limit further exposure to the offending agent. This would imply the patient is 100% occupationally disabled for work in the coal mining industry or similar dusty occupations." Dr. Baker attributed both the pneumoconiosis and respiratory impairment to the Claimant's coal mine dust exposure.

The Claimant also submitted progress notes by Dr. Baker from subsequent office visits in December 2002 and January 2003. DX-15. These notes are sketchy, but reiterate the Claimant's diagnoses and symptoms. Dr. Baker also conducted another pulmonary function test on January 30, 2003.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal

workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2004). In this case, Mr. Francisco's medical records indicate that he has been diagnosed with coal workers' pneumoconiosis, as well as chronic bronchitis.

20 CFR § 718.202(a) (2004) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Francisco has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, Mr. Francisco filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that

later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Upon consideration of the x-ray evidence of record, I find that the Claimant has failed to establish the existence of pneumoconiosis pursuant to Section 718.202(a)(1) on the basis of this evidence. The x-ray evidence includes interpretations of four chest rays. The first x-ray, taken by Dr. Dahhan, was read as negative. DX-13. There is no rereading of this film, and I find that it is a negative film. I likewise find that the x-ray taken on August 12, 2002 is a negative film. This x-ray was initially read by Dr. Simpao, an A reader, as positive, 1/1. DX-12. This x-ray was reread as negative by Dr. Halbert, a board certified radiologist. DX-16. I defer to the negative rereading by Dr. Halbert on the basis of his dual qualifications as a B-reader and board certified radiologist. I likewise find that the x-ray taken on November 23, 2002, is negative for the same reason. Although Dr. Baker is a B-reader, I will defer to the negative rereading of this film by Dr. Halbert on the basis of his superior credentials in the field of radiology. I do find that the last x-ray, taken on February 17, 2004 by Dr. Dahhan, is positive. I credit the positive rereading by Dr. Alexander on account of his qualifications as a board certified radiologist and B-reader, over the interpretation by Dr. Dahhan, who is a B-reader.

Notwithstanding Dr. Alexander's positive interpretation of the latest x-ray, I find that the x-ray evidence, taken as a whole, does not establish the existence of pneumoconiosis by a preponderance of the evidence. I find that the Claimant has failed to establish the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1) on the basis of x-ray evidence.

Because there is no biopsy or autopsy evidence, and the presumptions set for at 20 C.F.R. §§ 718.304, 718.305 and 718.306 do not apply, I will turn to the issue of whether the Claimant can demonstrate the existence of pneumoconiosis on the basis of medical opinions at 20 C.F.R. § 718.202(a)(4).

The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.* Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc).

The qualifications of the physicians are also relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him

episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence … ." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994).

Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 C.F.R. § 718.104(d) (2003). In the final analysis, the credibility of the treating physician's opinion may primarily rest on its "power to persuade." *Eastover Mining Co. v. Williams*, 338 F.3d 501, 513 (6th Cir. 2003). In assessing the probative value of these conflicting opinions, I must account for "the qualifications of the respective physicians, the explanation of their medical opinions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses." *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441 (4th Cir. 1997). *See also*, *Clark v. Karst-Robbins Corp.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc); *Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985). *Accord*, *Underwood v. Elkay Mining, Inc*.,105 F.3d 946, 950-951 (4th Cir. 1997).

I have reviewed in detail the medical opinions in support of the claim, and have accorded careful consideration to the conclusions of the Dr. Baker, in view of the fact that he saw the Claimant on multiple occasions and treated him for pulmonary problems, as well as his impressive credentials as a board certified internist and pulmonologist. *See Peabody Coal Co. v. Odom*, 342 F.3d 486, 492 (6th Cir. 2003); 20 C.F.R. § 718.104(d) (2003).

Nevertheless, I find that the detailed and comprehensive reports from Dr. Dahhan are sufficient to preclude a finding of coal workers' pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(4). This physician is likewise well qualified, being a board certified internist and pulmonologist.

I am mindful that an administrative law judge must consider a medical report as a whole, *see Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988), and *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984), and may not discredit an opinion merely because it is based on an x-ray interpretation which is outweighed by the other x-ray interpretations of record. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993); *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986); *cf. Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111 (1989). Nevertheless, where x-ray evidence constitutes an apparent major part of the physician's documentation, his opinion may be entitled to diminished probative weight if that specific film has been reread as negative, and the administrative law judge makes a specific finding to that effect. *See generally Director, OWCP v. Rowe*, 710 F.2d 251, 255 n. 6 (6th Cir. 1983). In this instance, Dr. Baker's diagnosis of pneumoconiosis rests on his positive x-ray reading. As to his diagnosis of chronic bronchitis, Dr. Baker explains "by history." He does not persuasively attribute Mr. Francisco's bronchitis to coal mine dust exposure, given the findings of "clear" lungs, without "rales or wheezes," and the negative findings on examination of the extremities.

Dr. Simpao's diagnosis of pneumoconiosis is also weakened by his reliance on his positive x-ray interpretation. That film, too, was reread as negative, and I have found that it constitutes a negative x-ray. Although Dr. Simpao also explained his diagnosis on the basis of examination findings and symptoms, I will defer to the opinion of Dr. Dahhan, who just a month before conducted a normal physical examination, because he is a board certified internist and pulmonologist, and his opinion is better supported by its underlying documentation.[6] I am mindful that I have found Dr. Dahhan's latest x-ray to be positive, and have taken this into account in weighing the medical opinion evidence in general, and in assessing the probative value of his conclusions. In addition, I note that Dr. Simpao's findings on physical examination are not consistent with the normal findings that were observed by Dr. Baker.

In the final analysis, I find that the Claimant has not established pneumoconiosis on the basis of medical opinion evidence.

Total Respiratory Disability

I also find that, assuming that the Claimant had proven that he suffers from pneumoconiosis, he has not established that he suffers from a totally disabling pulmonary or respiratory impairment.

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 C.F.R. § 718.304 (2004), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 C.F.R. § 718.204(b) and (c) (2004). I note that *any* loss in lung function may qualify as a total respiratory disability under Section 718.204(b)(2). *See Carson v. Westmoreland Coal Co.*, 19 B.L.R. 1-16 (1964), *modified on recon*. 20 B.L.R. 1-64 (1996).

The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and, in certain circumstances, (5) lay testimony. 20 C.F.R. § 718.204(b) and (d) (2004). Lay testimony, although relevant evidence, *see Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122 (1999), alone may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 C.F.R. § 718.204(d) (2004); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994).

There is no evidence in the record that Mr. Francisco suffers from complicated pneumoconiosis or cor pulmonale with right-sided heart congestion. I also find that the Claimant

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[6] Dr. Simpao's CV does not demonstrate that he is board certified, CX-1, and as noted above, I did not find him to be listed on the web-site maintained by the American Board of Medical Specialties. The Claimant's post hearing brief indicates that this physician is board certified in internal medicine and pulmonary disease.

has failed to demonstrate total respiratory disability pursuant to 20 C.F.R. §§ 718.204(b)(i) or (ii). None of the ventilatory and arterial blood gas tests produced results that qualify.

I must now determine whether the Claimant has demonstrated total respiratory disability on the basis of medical opinion evidence. 20 C.F.R. § 718.204(b)(2)(iv). Based on the above medical opinions, I find that the Claimant has failed to demonstrate total respiratory disability at Section 718.204(b)(2)(iv). I will first credit the medical assessment of Dr. Dahhan. His opinion that Mr. Francisco does not suffer from a total respiratory impairment is best supported by his physical examination results and the results of the non-qualifying clinical tests administered both by himself, and by the other physicians of record. I find that Dr. Dahhan's conclusions are thus better reasoned and documented.

I note that Dr. Simpao specifically observed the nature of activities that gave rise to Mr. Francisco's shortness of breath. Although his assessment of a mild impairment may support an finding of total disability if that impairment precludes a miner from returning to his last coal mine work, I discount Dr. Simpao's overall disability conclusions because they are undermined by the normal clinical test documentation, as well as Dr. Dahhan's contrary assessment. Turning to Dr. Baker's disability conclusions, I find that, on this record, his assessment of a Class 1 impairment using the AMA Guides does not prove that the Claimant is thereby prevented from returning to the mines. The conclusion that further coal mine dust exposure is medically contraindicated does not constitute an assessment of total respiratory disability under the Act. *See Taylor v. Evans and Gambrel Co., Inc.*, 12 B.L.R. 1-83 (1988); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988). *See also, Zimmerman v. Director, OWCP*, 871 F.2d 564 (6th Cir. 1989). Moreover, Dr. Baker relies on the non-qualifying pulmonary function test results to fix the level of the Claimant's respiratory disability -- thus the "Class 1" impairment rating from the *AMA Guides*. His overall opinion is less well documented than that of Dr. Dahhan.

The next step is to consider the medical, and relevant lay, evidence as a whole. In conclusion, viewing the non-qualifying clinical data, and Dr. Dahhan's disability conclusion as contrary probative evidence, and weighing all relevant evidence together, like and unlike, *see Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987), and *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986), I find that the record does not establish total respiratory disability. I have considered the Claimant's hearing and deposition testimony regarding his limitations and the work required by his last coal mine employment. Without corroborating medical evidence, however, this testimony cannot support a finding of total respiratory disability. *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122 (1999). *See also, Fife v. Director, OWCP,* 888 F.2d 365, 370 (6th Cir. 1989).

Weighing all relevant evidence, I thus find that the Claimant has not established total respiratory disability.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to establish either the existence of pneumoconiosis or total respiratory disability, each a requisite element of entitlement, I find that he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Jack R. Francisco on May 24, 2002, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2004), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.